MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PARTI: GENERA	PART I: GENERAL INFORMATION										
Type of Requestor:	(X)HCP ()IE () IC	Response Timely Filed? () Yes (X) No								
Requestor's Name and Address Nicolas Padron,, M. D.			MDR Tracking No.: M5-05-1663-01								
7125 Marvin D. Love #1	107		TWCC No.:								
Dallas, Texas 75237			Injured Employee's Name:								
Respondent's Name and Address Dallas County, Box 42			Date of Injury:								
			Employer's Name: Dallas County Sheriff Dept.								
			Insurance Carrier's No.: None given								
PART II: SUMMAI	RY OF DISPUTE AND	FINDINGS (Details on P	Page 2, if needed)								
	of Service										
From	То	CPT Code(s) or Description		Amount in Dispute	Amount Due						
10-18-04	10-18-04	CPT Code 99213		\$68.24	\$68.24						
PART III: REQUES	STOR'S POSITION SU	MMARY									
DADT IV. DESDON	IDENT'S POSITION S	IIMMADV									
TARTIV: RESTOR	DENT STOSITION S	UMIWARI									
DADT V. MEDICA	I DISDUTE DESALLE	TION DEVIEW-SUMMA	DV METHODOL	LOGY, AND/OR EXPLANAT	CION						
PART V: MEDICA	L DISPUTE RESOLUT	HON REVIEW SUMMA	KY, METHODOI	LOGY, AND/OK EAFLANA	HON						
This complex was denied as "N, not adaquate decomposition". Paviery of the office notes submitted reveal that this service does not the											
This service was denied as "N- not adequate documentation." Review of the office notes submitted reveal that this service does meet the documentation criteria set forth by the CPT Code descriptor for (CPT Code 99213).											

PART VI: DETAIL FINDINGS (If needed)											
Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due				
					Total l	Left Column:	\$0.00				
						\$0.00					
Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of \$68.24. The Division hereby ORDERS the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.											
Ordered by: Donr		ına Auby	6-22		2-05						
Authorized Signature			Typed Name		Date of Order						
PART VIII: YOUR RIGHT TO REQUEST A HEARING											
Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.											
The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.											
Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.											
PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION											
I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.											
Signature of Insurance Carrier: Date:											